DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 1, 2023

Licensee
Highland Senior Living
1012 3rd Avenue Northeast
Little Falls, MN 56345

RE: Project Number(s) SL30739015

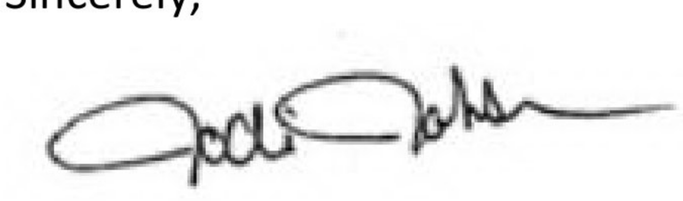
Dear Licensee:

On July 28, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 9, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

Electronically Delivered

July 5, 2023

Licensee
Highland Senior Living
1012 3rd Avenue Northeast
Little Falls, MN 56345

RE: Project Number(s) SL30739015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 9, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30739	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND SENIOR LIVING OF LITTLE FALLS	1012 3RD AVENUE NE LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30739015-0 On June 5, 2023, through June 7, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 63 active residents whom were receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on June 7, 2023, issued for SL30739015, tag identification 2310. On June 7, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 790 SS=D	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 1 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on June 6, 2023, at approximately 11:30 a.m. with licensed assisted living director (LALD)-A and maintenance (M)-H it was observed that the fire extinguisher provided in the Salon did not have the required annual maintenance performed according to MN Statute 144G.45.	0 790		

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0 790	Continued From page 2 LALD-A and M-H visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 6, 2023, at	0 800		

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0 800	Continued From page 3 approximately 11:45 p.m. with licensed assisted living director (LALD)-A and maintenance (M)-H it was observed that several fire-resistant rated doors including the parking garages were provided with kick down devices to hold the doors open. Several of the hold open devices were in use at the time of survey including the parking garage. Doors that are fire resistant rated in these rooms are required to be maintained closed and latched as designed and installed at the time of construction. This deficient condition was visually verified by LALD-A and M-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060		

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01060	Continued From page 4 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01060		

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01060	Continued From page 5 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 7, 2023, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated R7 had been hospitalized since June 1, 2023, and returned June 6, 2023, at 1:00 p.m., with orders to initiate hospice care. R7's service agreement dated March 10, 2023, indicated R7 received the following services: assistance with escorts, dressing, toileting, incontinence cares, ambulation, and housekeeping. R7's Resident Notes dated May 9, 2023, through June 7, 2023, indicated the following: - May 29, 2023, at 5:50 p.m., writer was called to resident's room. Resident is ashy in color, labored breathing, weak and very tired. He threw his dinner and states that he is nauseous. Son and daughter talked and decided to send him to the ER. Vital signs (VS) are in health monitoring. - May 31, 2023, at 6:19 a.m., a licensed practical nurse (LPN) wrote "noted". - June 6, 2023, at 4:39 p.m., an LPN wrote, "writer reached out for orders for foley cath care. Physician Care Provider (PCP) responded with : foley cath with care per facility policy. Copy given to LPN social worker (SW). Copy in chart." R7's After Visit Summary (AVS) dated June 6, 2023, indicated R7 was to have hospice care initiated at the facility, as R7 required a higher level of care.	01060		

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01060	Continued From page 6 R7's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R7's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On June 7, 2023, at 11:05 a.m., CNS-B stated the licensed assisted living director (LALD) "typically" took care of the notifications and CNS-B did not have a clear understanding of the emergency relocation regulation. CNS-B telephoned LALD-A and verified with LALD-A the emergency relocation written notice, nor the OOLTC notification had not been completed for R7 as required. The licensee's Service Plan policy updated December 2022, noted an emergency relocation is not a termination and the facility must provide a written notice to the residents, their legal representatives, and their designated representatives. A copy of the notice of emergency relocation must be provided to the	01060		

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01060	Continued From page 7 Office of Ombudsman for Long-Term Care if the resident has relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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01620	Continued From page 8 Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment by a registered nurse (RN) for four of five residents (R3, R2, R1, R7) with a change of condition, including addition of interventions as needed with change of conditions. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted to the facility on August 1, 2022. R3's diagnoses included Alzheimer's dementia and hypothyroidism. R3's service plan addendum dated October 1, 2022, indicated the resident received the following services: medication management and administration, monthly vital signs, assistance with incontinence cares, bathing, dressing, grooming, meal reminders, and oral cares, safety checks, behavior observation, housekeeping, and laundry. R3's 90-day nursing assessment dated April 20, 2023, indicated R3 had a severe cognitive impairment, required assistance with dressing, grooming, bathing, incontinent cares, was able to move about freely with or without device, wanders	01620		

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01620	Continued From page 9 without purpose, medication administration, and has no behaviors. R3's record indicated from May 6, 2023, through June 1, 2023, R3 had sustained 17 falls, as well as change in ambulation and cognition, as outlined in the incident reports (IR), and progress notes (PN) below: MAY 2023 -IR: May 6, 2023, at 6:45 a.m., witnessed fall in resident's living room, unlicensed personnel (ULP) reported resident tried to hit staff and lost her balance and fells. No injuries. The fall was reported to clinical nurse supervisor (CNS)-B. The incident report was completed by licensed practical nurse (LPN)-C and interventions documented was to ensure articles of need within reach, reeducate on safety and change position slowly, and to ensure staff are following the service plan. -PR: May 6, 2023, at 9:38 a.m., LPN-C noted R3 was standing and tried to hit staff and fell. -PR: May 6, 2023, at 1:00 p.m., LPN-C noted primary care provider (PCP) was updated on fall. PCP encouraged monitoring when behaviors are occurring to determine pattern or technique to incorporate behavioral modification. -IR: May 7, 2023, at 7:15 p.m., unwitnessed fall in resident's kitchen, ULP found resident on the floor during one of the hourly rounding checks. Resident unable to express what she was doing prior to the fall or how she fell due to her cognitive impairment, but there was pop on the floor where she was on the ground. It appears she slipped on the wet floor. No injuries. The fall was reported to LPN-J. Incident report was completed by LPN-K and interventions was to ensure articles of need within reach, reeducated on safety and to change position slowly, ensure proper footwear is	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND SENIOR LIVING OF LITTLE FALLS	1012 3RD AVENUE NE LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 10 available, and to ensure staff are following the service plan. -PR: May 8, 2023, at 9:16 a.m., (late entry for May 7, 2023, at 7:15 p.m.), LPN-K noted unwitnessed fall, found in doorway of apartment. Resident stated water on the floor, and pop was spilled. ULP stated resident was disorientated following the fall. -PR: May 8, 2023, at 10:23 a.m., PCP received notification of fall, update with any changes. -PR: May 8, 2023, at 12:35 p.m., LPN-K noted resident was having a hard time sitting up and getting out of bed. Assist of one to two to get resident out of bed and walking. Did not eat breakfast or lunch. Sitting in chair head down, drool running from mouth. Was taking resident to bathroom, resident in standing position and trying to hit at staff, LPN-K instructed ULP to try later. Resident would not lay in bed, remained in chair. -PR: May 8, 2023, at 6:58 p.m., LPN-L noted resident's brother was updated on current condition and discussed hospice. -PR: May 8, 2023, at 10:02 p.m., LPN-L noted resident could not be aroused for supper. No medications given. Assist of two to bathroom, appeared weak, complained of pain. Continue to monitor. -PR: May 9, 2023, at 8:13 a.m., LPN-K noted PCP requested update if resident had focal weakness, slurred speech, as concern of stroke. PCP will see resident tomorrow and discuss medications. Update PCP with any new and acute changes. -PR: May 9, 2023, at 1:28 p.m., LPN-K noted resident is assist of two for transfers, resident was fed, cannot grip utensils. Not drooling as much today. -PR: May 9, 2023, at 11:02 p.m., LPN-L noted continues assist of two with transfers and walking. More alert.	01620		

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01620	Continued From page 11 -PR: May 11, 2023, at 10:06 p.m., LPN-L noted resident ate supper in room, refuses to go to dining room. Assist of two with walking to bathroom, later one assist, then minimal assist with walking. -PR: May 12, 2023, at 11:27 a.m., LPN-C noted PCP sent order for hospice evaluation. -IR: May 13, 2023, at 1:43 p.m., unwitnessed fall in resident's kitchen, ULP heard resident calling for help. No injuries. Resident stated she slipped. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was to ensure articles of need within reach, reeducated on safety and change position slowly, ensure proper footwear is available, and to ensure staff are following the service plan. -IR: May 13, 2023, at 5:00 p.m., unwitnessed fall in resident's kitchen, ULP heard resident calling for help. She was found with no shoes on again, staff are encouraging to keep shoes on. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was to ensure articles of need within reach, reeducated on safety and change position slowly, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 13, 2023, at 5:40 a.m., (late entry for May 13, 2023, at 1:43 p.m.), LPN-K noted unwitnessed fall, resident was yelling for help, found sitting on the floor in her kitchen area. Resident only had socks on. -PR: May 13, 2023, at 5:42 p.m., LPN-K noted PCP received notification of fall, continue to monitor, and update if changes. -PR: May 13, 2023, at 5:54 p.m., LPN-K noted unwitnessed fall in apartment, resident had ted stockings (compression stockings) on but no shoes. -PR: May 14, 2023, at 8:48 a.m., LPN-K noted PCP received notification of fall, and stated may	01620		

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01620	Continued From page 12 be helpful to try a different pair of shoes, continue to monitor, and update with changes. -PR: May 14, 2023, at 6:30 p.m., LPN-K noted unwitnessed fall in apartment, resident was found sitting on her buttocks, did not have shoes on. Assist of 3 to get off the floor. -PR: May 15, 2023, at 9:48 p.m., LPN-C noted PCP received notification of fall, update with any changes. -IR: May 16, 2023, at 5:15 p.m., unwitnessed fall in resident's kitchen, ULP found resident on the floor in her room when staff went to check on her. Resident was agitated throughout the shift. Resident unable to say what happened. No injuries. Hospice came in to evaluate resident for injuries. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was to ensure articles of need within reach, reeducated on safety and to change position slowly, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 16, 2023, at 6:25 p.m., LPN-L noted unwitnessed fall in apartment, resident screaming and found her in sitting position in front of table. -PR: May 16, 2023, at 10:16 p.m., LPN-L noted hospice nurse came to evaluate after fall. -IR: May 19, 2023, at 5:35 p.m., unwitnessed fall in resident's kitchen, ULP found resident lying on her right side in front of her table, her chair was laying on its side at the top of the resident's head. Resident stated was trying to get up from table. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-L and interventions was to ensure articles of need within reach, reeducated on safety and to change position slowly, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 19, 2023, at 6:06 p.m., LPN-K noted unwitnessed fall in apartment, hospice notified,	01620		

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01620	Continued From page 13 sending someone to evaluate resident. -IR: May 20, 2023, at 5:40 p.m., unwitnessed fall in resident's living room, ULP found resident in sitting position in front of her recliner. Resident stated was trying to get out of chair. No injuries. Assist of two with gait belt to assist off the floor. The fall was reported to CNS-B. Incident report was completed by LPN-L and interventions was to ensure articles of need within reach, reeducated on safety to change position slowly, ensure proper footwear is available, and to ensure staff are following the service plan. -IR: May 20, 2023, at 6:40 p.m., unwitnessed fall in resident's kitchen of apartment. ULP found her sitting on kitchen floor. Resident stated was walking to her cupboard because she wanted chips and she fell. No injuries. The fall was reported CNS-B. Incident report was completed by LPN-L and interventions was to ensure articles of need within reach, reeducated on safety and to change position slowly, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 20, 2023, at 7:28 p.m., (late entry for 5:40 p.m., and 6:40 p.m.,) LPN-L noted two unwitnessed falls in her apartment. -PR: May 20, 2023, at 8:24 p.m., LPN-L noted hospice nurse assessed resident, no injuries, and resident may need to go to another facility with 24 hours a day nursing care. -PR: May 21, 2023, at 8:32 p.m., LPN-L noted unwitnessed fall in apartment, resident yelling for help, found in sitting position on floor by table -PR: May 21, 2023, at 9:07 p.m., LPN-L noted hospice coming to assess. -PR: May 22, 2023, at 8:32 a.m., LPN-C noted PCP received notification of fall, update with any changes. -IR: May 23, 2023, at 6:30 p.m., unwitnessed fall in resident's living room, ULP heard resident	01620		

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01620	Continued From page 14 yelling for help and was found sitting on floor in front of recliner. No injuries. Resident unsure how she fell. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was reeducated on safety and to change position slowly, wear gait belt, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 23, 2023, at 8:52 p.m., LPN-C noted unwitnessed fall in apartment yelling for help, found on floor in front of recliner -IR: May 24, 2023, at 4:00 p.m., unwitnessed fall in resident's living room, ULP entered room and found her on floor in front of recliner. Resident stated was getting up and fell out of chair. No injuries. The fall was reported to CNS-B. Incident report was completed LPN-L interventions was to ensure articles of need within easy reach, reeducated on safety and change position slowly, wear gait belt, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 24, 2023, at 8:10 p.m., LPN-L noted unwitnessed fall in apartment, yelling for help, found on floor in front of recliner. -IR: May 25, 2023, at 9:55 a.m., unwitnessed fall in resident's living room, ULP entered room and found her on floor in front of recliner. Resident stated she as trying to get out of the chair. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was to ensure articles of need within easy reach, reeducated on safety and to change positions slowly, wear gait belt, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 25, 2023, at 10:09 a.m., LPN-K noted unwitnessed fall in apartment, yelling for help, found on floor in front of recliner. -PR: May 25, 2023, at 10:32 a.m., LPN-K noted	01620		

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01620	Continued From page 15 PCP received notification of fall, update with any changes. -PR: May 25, 2023, at 10:32 a.m., CNS-B- noted brother moving rocking chair and another chair out of room and putting in a lift chair. -IR: May 26, 2023, at 7:00 a.m., unwitnessed fall in resident's living room, ULP heard resident yelling and found her on floor in front of chair. Resident states she was trying to stand up, but her legs were weak. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was to ensure articles of need within easy reach, reeducated on safety and to change position slowly, wear gait belt, ensure proper footwear is available, and to ensure staff are following the service plan. -PR: May 26, 2023, at 9:00 a.m., LPN-K noted PCP received notification of fall, update with any changes. -IR: May 26, 2023, at 9:40 a.m., unwitnessed fall in resident's living room, ULP found resident on floor in front of chair. Resident stated was trying to get out of chair and fell. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was to ensure articles of need within easy reach, reeducated on safety and to change position slowly, wear gait belt, ensure proper footwear is available, and to ensure staff are following the service plan. -IR: May 26, 2023, at 6:50 p.m., unwitnessed fall in resident's kitchen, ULP found resident on floor in kitchen. Resident unsure what happened. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-K and interventions was to ensure articles of need within easy reach, reeducated on safety and change position slowly, wear gait belt, ensure proper footwear is available, and to ensure staff are following the	01620		

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01620	Continued From page 16 service plan. -PR: May 26, 2023, at 7:16 p.m., LPN-L noted unwitnessed fall in apartment, yelling for help, found on floor at transition between carpet and tile. -PR: May 27, 2023, at 12:41 p.m., LPN-C noted PCP received notification of fall, update with any changes. -IR: May 27, 2023, at 5:05 p.m., unwitnessed fall in resident's living room of apartment, ULP found resident on floor with back against her recliner. Resident unsure what happened. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-C and noted resident's brother will remove recliner chair and will replace with a self-rising chair will be put in her room. Medications have been reviewed by PCP and changed to help with cognition." Interventions was reeducated on safety and rearrange furniture. -PR: May 27, 2023, at 5:13 p.m., LPN-C noted unwitnessed fall in apartment on floor in front of recliner. -IR: May 28, 2023, at 7:35 a.m., unwitnessed fall in resident's kitchen, ULP found resident on floor by doorway. Resident unsure what happened. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-C and intervention was reeducated on safety. -PR: May 28, 2023, at 7:50 a.m., LPN-C noted unwitnessed fall in apartment on floor at doorway. -PR: May 28, 2023, at 3:21 p.m., LPN-C noted PCP received notification of fall, update with any changes, recheck blood pressures and update. -IR: May 29, 2023, at 2:45 p.m., unwitnessed fall in resident's living room, ULP found resident on floor in front of recliner. Resident unsure what happened. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-C. Intervention was reeducated on safety. -PR: May 29, 2023, at 3:03 p.m., LPN- C noted	01620		

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01620	Continued From page 17 unwitnessed fall, found on floor next to recliner. -PR: May 29, 2023, at 4:11 p.m., LPN-C noted PCP received notification of fall, update with any changes. R3's record did not identify a new intervention after each fall or hospice admission, nor was an assessment completed after each fall or hospice admission in May 2023. JUNE 2023 -IR: June 1, 2023, at 11:30 a.m., unwitnessed fall in dining room of commons area ULP found resident sitting on floor with legs under dining room table, wheelchair was back behind her. No injuries. The fall was reported to CNS-B. Incident report was completed by LPN-C and interventions was gripper socks, ensure articles of need within easy reach, reeducated on safety, wear gait belt, ensure staff are following the service plan. -PR: June 1, 2023, at 11:42 a.m. LPN-C noted unwitnessed fall in commons dining room, sitting on floor with legs under dining room table, wheelchair pushed back behind her. -PR: June 1, 2023, at 12:27 p.m., LPN-C noted PCP received notification of fall, update with any changes. R3's record did not identify a new intervention after the fall, nor was an assessment completed after the fall in June 2023. On June 6, 2023, at 9:30 a.m., CNS-B stated the gap between assessments was due to lack of full-time nurse at the facility, regional nurse was assisting the facility during this time. On June 7, 2023, at 12:47 p.m., the surveyor observed R3's door opened and heard her yelling for help. ULP-E entered and found her on floor	01620		

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01620	Continued From page 18 next to her chair. ULP-E stated resident was checked 20 minutes ago and she would have been toileted at that time. ULP-E called CNS-B for assistance. CNS-B came to her room to assess. A Hoyer lift (mechanical lift) was used to assist resident back into her recliner. On June 7, 2023, at 1:57 p.m., regional registered nurse director (RD) -I stated there was no change of condition assessment completed following the falls. R2 R2's diagnoses included dementia, diabetes, and chronic post-traumatic stress disorder (PTSD). R2's service plan dated March 17, 2023, indicated R2's services included monthly vital checks, meal reminders, dressing, oral cares, behavior observation, medication administration, blood sugar checks, housekeeping, and laundry. R2's assessment dated May 24, 2023, indicated R2 had severe cognitive impairment, wandered, had behavior issues both verbal and physical, required assistance with dressing, grooming, oral care, eating, ambulation, transfers, toileting/incontinence cares, repositioning, and bathing. R2 had sensory deficits of vision, was hard of hearing and had expressive aphasia (disorder affecting ability to use or understand language). R2 used a four wheel-walker, wheelchair and sit-to-stand for transfers due to balance problems while standing and decreased muscular coordination. R2's diet was pureed due to difficulty with swallowing. On June 5, 2023, at 11:20 a.m., the surveyor observed LPN-C conduct a blood sugar check for R2 with a result of 165 mg/dL (milligrams per	01620		

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01620	Continued From page 19 deciliter) and assist R2 with ambulation. R2's Resident Notes dated May 8, 2023, through June 5, 2023, indicated R2 had three of five falls unassessed by an RN during the time period: -May 13, 2023, at 8:01 p.m., an LPN wrote, "this afternoon he was sitting in his recliner with his pants off and his brief was almost completely off. He had tipped his water cup over and slipped on his floor in front of his chair. Area was cleaned up and resident was redressed and assisted to bed to lay down due to how tired he was." -May 14, 2023, at 8:52 a.m., an LPN wrote, "Late entry for May 13, 2023, at 6:40 p.m.: Resident was found on one knee by the wall. No complaints of pain. No injuries noted. Resident unable to say what had happened. Resident was very tired the entire shift. PCP notified. Hospice notified. Family notified." -June 1, 2023, at 7:38 a.m., an LPN wrote, "Resident had a fall this morning. No injury noted. Resident complains of mid/lower back pain. Hospice was notified and will be out to assess resident later today. PCP notified." R2's record lacked a reassessment by an RN for the change in conditions noted above. On June 7, 2023, at 3:40 p.m., CNS-B and RD-I stated resident reassessments should be completed with any changes in a resident's condition which included falls and changes in health status. R1 R1's diagnoses included dementia, generalized anxiety and depression. R1's service plan dated August 2, 2022, indicated R1 received the following services: medication	01620		

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01620	Continued From page 20 administration, dressing/cueing, monthly vital signs, exercise program and housekeeping. R1's assessment was completed on June 1, 2023, by CNS-B and indicated R1 had severe cognitive impairment, forgetful, confused, was prescribed antipsychotic medication for anxiety and hallucinations, required assistance with toileting, incontinence cares, grooming, dressing, oral care, and bathing. The assessment further indicated R1 used a 4-wheel walker for ambulation, was able to safely move about freely with/without a device, had a history of urinary tract infection, did not require compression treatments, did not require eyeglasses and R1 had no condition that effected ability to navigate to or from and participate in activities. On June 5, 2023, at 12:05 p.m., the surveyor observed unlicensed personnel (ULP)-D and ULP-E assist R1 in preparing for lunch. ULP-D and ULP-E assisted R1 from a lying position in R1's bed to a partial standing position with the use of a sit-to-stand mechanical lift. ULP-E provided cueing instructions to R1, with little response from R1. ULP-D assisted with providing hands-on body support to R1. R1 lacked the strength to safely and securely hold on to the handle grips of the mechanical lift which allowed the securing belt to rise at and above chest level on R1. On June 5, 2023, at approximately 12:20 p.m., the surveyor interviewed ULP-E and asked if ULP-E felt R1 was safe while being transferred with the sit-to-stand mechanical lift. ULP-E stated it was not safe to transfer R1 in the sit-to-stand, "we have told the nurses lots of times, we have told the family. The bed is too high for the Hoyer (mechanical lift with a body sling) and she isn't	01620		

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01620	Continued From page 21 strong enough to help with the sit-to-stand". On June 6, 2023, at 8:30 a.m., the surveyor observed ULP-E and ULP-F provide grooming, dressing and incontinence cares to R1. When morning cares were completed, ULP-E and ULP-F transferred R1 from her bed to a manual wheelchair with a Hoyer lift. ULP-F provided ambulation for R1 from her room to the main dining room for breakfast and R1 was assisted with feeding from ULP-G. R1's Resident Notes dated May 8, 2023, through June 5, 2023, indicated: -May 8, 2023, at 4:56 p.m., an LPN wrote, "resident noted to have a red mark 10 cm (centimeter) linear side of left upper calf area, lines up to metal piece that pushes pedal out of the way (wheelchair). No drainage, Res [resident] denied pain, no warmth, ROM (range of motion) WNL (within normal limits). Resident does not know how she obtained it, will monitor. Right leg near knee has 8 cm linear mark. Appears from TED socks (compression stockings). Resident denies pain. No drainage, no warmth, ROM WNL. Will monitor. Texted provider regarding new skin concerns. Family notified." -May 25, 2023, at 4:27 p.m., an LPN wrote " Resident had med (medium) amount of emesis, phlegmy with light brown puree like substance. Resident would not answer writer when asked if stomach hurt. Stomach slightly distended. Resident is on third day without a bowel movement. Will give Miralax. Will monitor. Updated family. Updated provider." [vital signs included within note] -June 1, 2023, at 10:24 p.m., an LPN wrote, " Resident noted to be leaning towards left side in chair. Resident was using stand device with transfers to bathroom. Resident does not hang on	01620		

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01620	Continued From page 22 safely at this time. Writer instructed HHAs (home health aides) to use Hoyer lift (mechanical lift device that uses a body sling) if needed. Resident face flushed. Retook blood pressure with manual was 136/78. Grip strength equal. Resident at baseline for orientation. Smile equal no drooping." -June 1, 10:58 p.m., an LPN wrote, " resident noted to be leaning towards left side last couple of days. VS taken. Blood pressure 162/92 retaken manually 136/78. Grip strength equal, no facial drooping noted. Resident orientation is baseline. Face flushed. Has been eating with fingers not using utensils. Denied pain or weakness. Please advise." [note written to provider from LPN] -June 2, 2023, at 10:24 a.m., an LPN wrote, "HHA reported left lip drooping this morning but when I went to assess she was crying and I did not note any drooping. Hand grip is light but equal. Pupils normal. Just really leaning to the left in her chair." -June 2, 2023, at 11:14 a.m., an LPN wrote, " provider follow up on change of condition" Physician assistant thanked LPN for update via electronic messaging system and noted "if there is concern for facial drooping, change in gait, slurred speech, focal weakness, would recommend contacting resident's son and power of attorney to determine if he would like patient assessed in emergency department for concerns of stroke." -June 2, 2023, a second note entered from an LPN at 10:58 p.m., "Resident continues to lean towards left. Needed assistance with eating. No facial drooping noted. No other symptoms d/t (due to stroke). Baseline orientation. Will monitor." -June 3, 2023, at 12:51 p.m., an LPN wrote, "Resident has a bruise on her left lower leg right	01620		

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01620	Continued From page 23 above the ankle measuring 4cm x1cm (centimeter). At the end of the bruise resident has a circle skin tear that was bleeding. Band-aid was applied. Physician notified. Family notified." -June 3, 2023, at 6:44 p.m., an LPN wrote, " Resident continues to lean towards the left side. Resident needed assistance with feeding all three meals. No facial drooping noted. No other symptoms of stroke. Baseline to orientation. Will continue to monitor." -June 4, 2023, at 11:19 a.m., an LPN wrote, "details: monitor and apply band-aid everyday - monitor and report signs symptoms of infection per provider. Copy placed in chart. Electronic medical record (EMAR) updated. Services added. Family aware." -June 4, 2023, at 6:49 p.m., an LPN wrote, "Resident continues to lean towards the left side. Resident needed assistance with feeding all three meals. No facial drooping noted. No other symptoms of stroke. Baseline to orientation. Will continue to monitor." -June 5, 2023, at 8:36 a.m., an LPN wrote, " No signs symptoms of infection noted. Some dried blood on bandage. Skin is normal temp to the touch. Wound bed pink in color. New bandage applied per orders." On June 7, 2023, at approximately 9:15 a.m., CNS-B stated R1 was being sent to the emergency department (ED) for an evaluation. CNS-B stated R1 had "a rough night" and CNS-B was not aware of the changes in condition until CNS-B had received the morning email report/update from corporates triage on-call nurse on June 7, 2023, at 8:30 a.m. R1's record lacked a reassessment by an RN for changes in condition noted above.	01620		

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01620	Continued From page 24 On June 7, 2023, at 3:40 p.m., CNS-B stated a change of condition assessment had not been completed since R1's last assessment on May 1, 2023, and stated "we are working on those." CNS-B stated there was a gap with assessments between RN's and the facility got behind due to the instability of the nursing department. R7 R7's diagnoses included dementia, congestive heart failure (CHF) and sciatica. R7's service plan dated March 10, 2023, indicated R7's services included dressing, toileting, incontinence care, escorts, ambulation assist and housekeeping. R7's assessment dated May 1, 2023, indicated R7 received home health aide assistance from the Veterans Administration (VA), had moderate cognitive impairment, confused at times during the day, impaired decision making, required assistance with mobility, transfers, dressing, incontinence cares and bathing. R7 used a cane and a four-wheel walker with assistance for ambulation. On June 7, 2023, at 12:50 p.m., the surveyor observed ULP-G assist R7 to lay in a hospital bed with bilateral upper bedrails placed into the upright position by ULP-G. R7's Resident Notes dated May 9, 2023, through June 6, 2023, indicated the following: -May 9, 2023, at 10:33 p.m., an LPN wrote, "Resident was in his room walking with walker to sit on his recliner. Miscalculated where recliner was as he was crouching down to sit. Resident said he was grabbing onto anything to slow his fall. Hit back of head (not hard). When writer	01620		

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01620	Continued From page 25 entered room was resident in supine position on the floor near his recliner." Per note, resident initially requested to be seen at emergency department due to back pain, however, had later decided not to go to emergency department. -May 18, 2023, at 10:19 p.m., an LPN wrote, "Resident said he had a procedure done today. Resident has been bleeding from his scrotum. Home Health Aide (HHA) has changed his brief and pad 6 times throughout shift. HHA states she believes there is a hole on his scrotum. Writer was unable to go up and check at this time. Resident is in bed." -May 21, 2023, at 1:48 p.m., an LPN wrote, "HHA informed writer resident fell in bathroom. When writer walked in bathroom resident was lying in supine position, head by toilet and feet by shower. Resident said he was going to go to toilet. Turned to fast with walker and lost his balance. No injuries or skin issues noted at the time of fall. Able to move extremities free of pain. Denied hitting head. Resident said he did have dizziness before falling. Resident able to answer questions appropriately. Resident gotten up with Hoyer lift and 2. Resident was put on the walker seat, HHA assisted resident to toilet. Resident had large emesis undigested food. Asked resident if wanted to go to emergency room, resident stated no. Informed family, faxed PCP, incident report done, post huddle done." -May 22, 2023, at 4:26 p.m., an LPN wrote, "resident's family wanted resident sent in via non-emergency ambulance due to resident still having some dizziness at times along with him almost having another fall. Resident had been walking fine 20 minutes prior when he used the bathroom, 20 minutes later daughter wanted him to go to the bathroom again before he left. Resident walked fine to bathroom, once he got to the toilet and was sitting on the toilet resident	01620		

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01620	Continued From page 26 leaned towards the left side. Resident was very confused, he thought it was 2022. He did not know where he was at. It took him about 10 minutes to say he was at [name of facility]. Resident left in non-emergency ambulance at 4:10 p.m." -May 29, 2023, at 5:50 p.m., an LPN wrote, "writer was called to resident's room. Resident is ashy in color, labored breathing, weak and very tired. He threw his dinner and states that he is nauseous. Son and daughter decided to send him to [out of town emergency department]." R7's record lacked a reassessment by an RN for changes in condition noted above. On June 7, 2023, at 3:40 p.m., CNS-B and RD-I stated resident reassessments should be completed with any changes in a resident's condition which included falls and changes in health status. Additionally, CNS-B stated, "I would go in after hours if I needed too." The licensee's Comprehensive Assessment Schedule policy updated August 2022, noted a registered nurse would conduct a face-to-face reassessment in the resident's residence with changes in a resident's condition as indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 27 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for two of five residents (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01650		

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01650	Continued From page 28 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included dementia and diabetes. R2's service plan dated March 17, 2023, indicated the resident received the following services: medication management, dressing, meal reminders, monthly vital signs, oral cares, behavior observation, housekeeping and laundry. On June 5, 2023, at 11:20 a.m., the surveyor observed licensed practical nurse (LPN)-C conduct a blood sugar check for R2 with a result of 165 mg/dL (milligrams per deciliter) and assist R2 with ambulation/escort. R1 R1's diagnoses included dementia, depression and generalized anxiety. R1's service plan dated August 2, 2022, indicated R1 received the following services: medication administration, exercise program assistance, dressing, bathing, monthly vital signs and housekeeping. On June 6, 2023, at approximately 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F provide morning cares for R1. ULP-E and ULP-F provided incontinence cares, a brief change, dressing, grooming, transfer with a Hoyer lift (mechanical body sling lift system) from R1's bed to a manual wheelchair and medication administration. ULP-F provided ambulation assistance for R1 from R1's room to the main	01650		

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01650	Continued From page 29 dining room where ULP-G assisted R1 with feeding. R2 and R1's service plans lacked the following required content: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; and -the identification of staff or categories of staff who will provide the services. On June 7, 2023, at approximately 3:40 p.m., clinical nurse supervisor (CNS)-B and regional RN director (RD)-I stated resident service plans may not be current and updated to reflect the required content noted above, however, "we are working on that". The licensee's Service Plans policy updated December 2022, noted all services provided to residents would be delivered after an assessment by a registered nurse (RN) was completed, an up-to-date service plan was signed by an RN and the resident or the resident's designated representative. The service plans would include the following: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; and -the identification of staff or categories of staff who will provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

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01880	Continued From page 30	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 5, 2023, at 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A, including a review of the medication refrigerator in the secured nurse's office. LALD-A stated there should be a temperature gauge in the medication refrigerator, temperatures are monitored daily and documented in the electronic health record. LALD-A looked around the refrigerator area and stated the temperature gauge was missing. The surveyor asked for the April and May medication refrigerator logs. The refrigerator contained the	01880		

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01880	Continued From page 31 following medication: - one unopened vial of glargine 100 units/milliliter (ml) insulin for resident (R8). The manufacturer's instructions for glargine insulin vials dated June 2022 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the glargine to freeze. On June 5, 2023, at 12:58 p.m., LALD-A stated there was no documentation of the medication refrigerator temperatures. The licensee's Medication and Treatment policy revised on March 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care,	02310		

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02310	Continued From page 32 medical, or nursing standards for one of four residents (R7) with bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate correction order issued on June 7, 2023. The findings include: On June 7, 2023, at 12:50 p.m., the surveyor observed unlicensed personnel (ULP)-G assist R7 to lay in a hospital bed with bilateral upper bedrails placed into the upright position by ULP-G. R7's diagnoses included dementia and congestive heart failure (CHF). R7's service plan dated March 10, 2023, indicated the resident received the following services: assistance with transferring, positioning, toileting, escorts, dressing, grooming, housekeeping and laundry. R7's assessment dated May 1, 2023, indicated R7 was partially incontinent, had severe short term memory impairment, was confused off and on throughout the day and had poor decision making skills. The "Physical Device" category of R7's assessment, incorrectly indicated R7 did not have a hospital bed, bedrails or positioning	02310		

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02310	Continued From page 33 devices. R7's record lacked a bedrail assessment to include the hospital bed with bilateral side rails, documentation of education to resident or representative, risks versus benefits, measurements of the entrapment zones, and safety review by a registered nurse (RN). On June 7, 2023, at 12:50 p.m., the surveyor interviewed ULP-G and ULP-G stated the bilateral bedrails are raised and used each time R7 is in the bed for a nap or overnight sleep. Additionally, ULP-G stated, the hospital bed had been in use for "over a month". On June 7, 2023, at 1:25 p.m., clinical nurse supervisor (CNS)-B stated she was unaware R7 had a hospital bed and the assessment provided to the surveyor was the only assessment completed and did not include an assessment of the hospital bed with upper bilateral bedrails used by R7. Additionally, CNS-B stated R7 had returned from the hospital on June 6, 2023, at 1:00 p.m., however, CNS-B had been unable to complete an assessment, but, would get an assessment "completed before the end of today." On June 7, 2023, at 2:30 p.m., CNS-B measured R7's bedrails with the surveyor present. R7's hospital bedrails zone 1 (space between the rails), and 3 were less than 4 and 3/4 inches, which was compliant with FDA guidelines. CNS-B verified the bedrails were securely fastened to the bed. The licensee's Siderail policy dated July 8, 2022, indicated when siderails are used the RN would conduct an assessment to identify the intended purpose of the siderail and the risks regarding the	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND SENIOR LIVING OF LITTLE FALLS	1012 3RD AVENUE NE LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 34 use of the siderail. Staff from the facility shall determine if the siderail is considered to be safe. "Safe" shall be defined as the siderail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means siderail zones 1, 2, and 3 must not exceed 4.75 inches. Zone 3 must not exceed 2.375 inches. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by review by evaluation supervisor on June 7, 2023, however non-compliance remains at a scope and level of three, widespread (G).	02310		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *06/05/23*
Time: 11:30:00
Report: 1017231120

Food and Beverage Establishment Inspection Report

Location:
Highland Senior Living
1012 3rd Avenue Ne
Little Falls, MN56345
Morrison County, 49

Establishment Info:
ID #: 0038142
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206321880
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE KITCHEN
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE SERVING KITCHEN MEMORY CARE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: EGG ROLL LOCATED UNDER COUNTER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: CHICKEN LOCATED IN WARMER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 162 Degrees Fahrenheit - Location: BROCCOLI LOCATED IN WARMER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: CHICKEN FRIED RICE LOCATED IN WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 32 Degrees Fahrenheit - Location: MILK LOCATED UNDER COUNTER
Violation Issued: No

Type: Full
Date: *06/05/23*
Time: 11:30:00
Report: 1017231120
Highland Senior Living

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

DISCUSSION

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017231120 of 06/05/23.

Certified Food Protection Manager: DOLORES JEAN BERGLUND

Certification Number: FM63668 Expires: 07/10/24

Signed: _____
Establishment Representative

Signed: _____

NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231120

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 06/05/23
Time In 11:30:00
Time Out

Highland Senior Living	Address: 1012 3rd Avenue Ne	City/State: Little Falls, MN	Zip Code: 56345	Telephone: 3206321880
License/Permit #: 0038142	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
Proper cooking time & temperature			
19	IN OUT N/A N/O		
Proper reheating procedures for hot holding			
20	IN OUT N/A N/O		
Proper cooling time & temperature			
21	IN OUT N/A N/O		
Proper hot holding temperatures			
22	IN OUT N/A		
Proper cold holding temperatures			
23	IN OUT N/A N/O		
Proper date marking & disposition			
24	IN OUT N/A N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	IN OUT N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	IN OUT N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
Food additives: approved & properly used			
28	IN OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	IN OUT N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 06/06/23

Inspector (Signature)